STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155252	A. BUILDING 01 B. WING	12/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-WOODLANDS	4088 FRAME RD NEWBURGH, IN47630

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K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 12/20/11 Facility Number: 000155 Provider Number: 155252 AIM Number: 100266830 Surveyor: Lex Brashear, Life Safety Code Specialist At this Life Safety Code survey, Golden Living Center-Woodlands was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and was fully	K0000	*Preparation and submission of this Plan Of Correction does not constitute any admission or agreement of any kind by the facility of the truth of any conclusion set forth in this allegation. Accordingly, the facility has prepared and submits this Plan of Correction solely as a requirement under State and Federal Law that mandates a submission of a Plan of Correction as a condition to participate in Title 18 and 19 programs, and to provide the best possible care to our residents as possible.*	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has a capacity of 120 and had a census of 103 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/22/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0025 SS=E	Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the facility failed to ensure 1 of 8 smoke barrier walls provided at least a one half hour fire resistance rating. This deficient practice could affect 35	K0025	**K025 -- What corrective actions will be accomplished for those residents found to have been effected by the deficient practice** Corrective action taken consisted of contacting Tri State Fire Protection Services to patch all large breaks in the firewalls in	01/05/2012

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	residents, as well as staff and visitors in the 500 and 600 Halls. Findings include: Based on observation on 12/20/11 at 2:15 p.m. during a tour of the facility with the Director of Maintenance, the smoke barrier wall above the smoke barrier doors between the 500 and 600 halls had four, four inch by six inch holes through the wall which were not fire stopped. This was acknowledged by the Director of Maintenance at the time of observation. 3.1-19(b)		the attic with Fireproof Drywall.All small penetrations will be sealed with fire barrier seal caulking. **- -How other residents have the potential to be affected will be identified** No other residents affected **--What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** Maintenance department/Designee to inspect all attic walls on completion of any subcontracted job requiring attic access for any damage to the fire/smoke walls. Any damage will be immediately repaired with approved fire barrier products. **- -How the corrective action will be monitored to ensure the deficient practice will not recur, what QA program will be put into place.** Maintenance will report any deficient practice to executive director who will report in QA monthly x 6 months unless further monitoring is deemed necessary at that time. **- -Systemic changes will be completed by January 5th 2012.**	

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K0029 SS=E	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 1. Based on observation and interview, the facility failed to ensure 1 of 12 hazardous area room doors, such as a kitchen door, would close and latch into its door frame. This deficient practice could affect any of the 103 residents, as well as staff and visitors while in the dining room. Findings include: Based on observation on 12/20/11 at 11:45 a.m. during a tour of the facility with the Director of Maintenance, the kitchen door from the dining room was not provided with a latching device. The only way for the door to stay closed was with a slide latch on the kitchen side of the door. This was acknowledged by the Director of Maintenance at the	K0029	**K029 -- What corrective actions will be accomplished for those residents found to have been effected by the deficient practice** Lensing Building contacted for review and repair of kitchen door and latch. The soiled utility room door was adjusted for appropriate closure. **--How other residents have the potential to be affected will be identified** All residents affected equally. **--What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** New fire door for kitchen ordered on 1/5/2012 for replacement. Door is a special order and will be installed upon receipt of door.Soiled utility room door was readjusted for appropriate closure. Maintenance department or designee will check door weekly for proper closure x 4 weeks and then monthly thereafter. **--How the corrective action will be monitored to**	01/06/2012

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	time of observation. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 12 hazardous area room doors, such as a Soiled Utility room door, was equipped with a properly operating self closing device on the door. This deficient practice could affect 28 residents, as well as staff and visitors in the 100 hall. Findings include: Based on observation on 12/20/11 at 12:30 p.m. during a tour of the facility with Director of Maintenance, the 100 hall Soiled Utility room door was provided with a self closing device, however, the door did not close completely when tested several times. There was a one half inch gap between the door and its frame when closed. This room was over 50 square feet in size and contained three soiled linen barrels at the time of observation. This was acknowledged by the Director of Maintenance at the		**ensure the deficient practice will not recur, what QA program will be put into place.** No further corrective action required on the kitchen door once new door installed with appropriate latching.Soiled utility room door will be checked weekly x 4 weeks and then monthly thereafter for proper closure. Results will be given to Executive director to report in QAA monthly x 6 months unless further monitoring is deemed necessary at that time. **--Systemic changes will be completed by January 6th 2012.**	

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	time of observation. 3.1-19(b)			
K0050 SS=F	Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 Based on record review and interview, the facility failed to provide quarterly fire drill documentation for 1 of 3 shifts during 1 of 4 quarters. This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's fire drills in the Life Safety Code Documents book on 12/20/11 at 10:45 a.m. with the Director of Maintenance, the facility lacked written documentation a fire drill was conducted during the third (night) shift of the second quarter (April, May, and June) of 2011. This was acknowledged by the	K0050	**K050 -- What corrective actions will be accomplished for those residents found to have been effected by the deficient practice** Maintenance department to be inserviced on timeliness of fire drills. **--How other residents have the potential to be affected will be identified** All residents affected equally. **--What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** Maintenance department to hold 1 fire drill per quarter for all 3 shifts. A different shift to host fire drill each month. Executive Director/designee will review building engines program monthly for completion of fire drills. **--How the corrective action will be monitored to ensure the deficient practice will not recur,**	01/13/2012

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	Director of Maintenance and the Administrator at the time of record review. 3.1-19(b)		**what QA program will be put into place.** Maintenance Department to report to Executive Director the fire drill inservice held each month with staff which will be reported in QAA x 6 months unless further monitoring is deemed necessary at that time. **--Systemic changes will be completed by January 13th 2012.**	
K0062 SS=E	Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 1. Based on observation and interview, the facility failed to ensure 1 of over 400 sprinkler heads in the facility were free of corrosion. NFPA 101 Section 9.7.5 refers to NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2-2.1.1 requires sprinklers to be free of paint. Any sprinkler shall be replaced that is painted or corroded. This deficient practice could affect mostly staff while in the Service Hall or telephone room. Findings include: Based on observation on 12/20/11 at 11:55 a.m. during a tour of the facility with the Director of Maintenance, the sprinkler head in the telephone room next to the reach-in freezer was covered with corrosion. This was acknowledged by the Director of Maintenance at the time of observation. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler heads in the Employee Breakroom bathroom was free of obstructions to the spray pattern. NFPA 101 Section 9.7.5 refers to NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2-2.1.2 requires unacceptable obstructions to spray patterns shall be	K0062	**K062 -- What corrective actions will be accomplished for those residents found to have been effected by the deficient practice** Tri State Fire Protection contacted for review and repair of the fire sprinkler heads. **--How other residents have the potential to be affected will be identified** All residents affected equally. **--What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** Tri State Fire Protection replaced the corroded sprinkler head in the telephone room and relocated the sprinkle head in the employee bathroom to the proper distance from the wall. Fire sprinkler heads will be monitored for corrosion by the maintenance department monthly **--How the corrective action will be monitored to**	01/05/2012

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	corrected. Furthermore NFPA 13, Standard for the Installation of Sprinkler Systems, 5-5.5.1 requires sprinklers shall be located as to minimize obstructions to discharge. NFPA 13 at 5-6.3.3 requires a minimum of 4 inches between the sprinkler and the wall. This deficient practice could mostly staff while in the Employee Breakroom. Findings include: Based on observation on 12/20/11 at 1:35 p.m. during a tour of the facility with the Director of Maintenance, the pendant sprinkler head in the Employee Breakroom bathroom was within one inch of the wall which could restrict the spray pattern of the sprinkler head in the event the sprinkler head was actuated. This was acknowledged by the Director of Maintenance at the time of observation. 3.1-19(b)		**ensure the deficient practice will not recur, what QA program will be put into place.** Fire sprinkler heads will be monitored for corrosion by the maintenance department monthly and be reported to the Executive Director who will report findings in QAA monthly x 6 months unless further monitoring is deemed necessary at that time. **-** **-Systemic changes will be completed by January 5th 2012.**	